TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
MILLENNIUM CHIROPRACTIC

Respondent Name
AMERICAN ZURICH INSURANCE CO

MFDR Tracking Number
M4-15-0145-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
September 11, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The patient was evaluated and treated accordingly due to the medical necessity of her injuries, from a work related incident, to avoid deterioration of her condition and maintain the functional improvements gained by therapy, WHICH WAS APPROVED. All physical therapy treatment for this patient should be paid immediately as the 'medical necessity' of treatment is inherent within procedure authorization. Furthermore, our treatment plan follows the ODG Guidelines..."

Amount in Dispute: $6,358.28

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Subject to further review, the carrier asserts that it has paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 3, 2013 through January 9, 2014	98941, G0283, 97110, 97112, 97140, 90791, 99080-73 and 90834	$6,358.28	$3,285.33

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.305 sets out the procedure for Medical Fee Dispute Resolution.
3. 28 Texas Administrative Code §129.5 sets out the guidelines for Work Status Reports.
4. 28 Texas Administrative Code §134.600 sets out the guidelines for preauthorization, concurrent review, and voluntary certification of healthcare.
5. 28 Texas Administrative Code §134.203 sets out the fee guidelines for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.

6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 247 – A payment or denial has already been recommended for this service.
   - B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment.
   - 191 – At the adjusters request no allowance was made
   - 216 – Based on the Findings of a Review Organization
   - 285 – Please refer to the note above for a detailed explanation of reduction. Bill is denied per adjuster. Exceeds pre-authorization
   - 6485 – At the adjusters request, no allowance was made
   - 198 – Precertification/authorization exceeded

Issues

1. Did the requestor submit copies of preauthorization letters in support of the disputed charges?
2. Is the requestor entitled to reimbursement for dates of service December 4, 2013 and December 5, 2013?
3. Is the requestor entitled to reimbursement for dates of service December 11, 2013 through January 9, 2014?
4. Is the requestor entitled to reimbursement for date of service October 3, 2013 through November 20, 2013?
5. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor in support of the disputed services submitted copies of preauthorization letters issued by IMO.

IMO PREAUTHORIZATION DATED 8/26/2013	
CPT Code(s)	97110, 97112, 97140, G0283 and 98940
Authorization #	58862
Start Date	8/26/2013
End Date	10/3/2013
# Sessions Authorized	12

IMO PREAUTHORIZATION DATED 10/18/2013	
CPT Code(s)	97110, 97112, 97140, G0283 and 98940
Authorization #	60323
Start Date	10/18/2013
End Date	11/17/2013
# Sessions Authorized	4

IMO PREAUTHORIZATION DATED 10/22/2013	
CPT Code(s)	90834
Authorization #	60389
Start Date	10/22/2013
End Date	11/21/2013
# Sessions Authorized	4

2. The requestor seeks reimbursement for CPT Codes 90834, 98941, G0283-GP, 97140-GP-59, 97110-GP and 97112-GP-59 rendered on December 4 and December 5, 2013. The insurance carrier denied/reduced the disputed services with reason code(s):
   - 247 – A payment or denial has already been recommended for this service
   - B13 – Previously paid. Payment for this claim/service may have been provided in a previous pay
   - 191 – At the adjusters request no allowance was made
   - 198 – Precertification/authorization absent

The table below outlines the denial reasons raised by the insurance carrier during the medical bill review process:

DOS	CPT code	EOB 5/15/14	EOB 12/23/13
12/4/13	98941	247, B13	191, 198
	G0283-GP	247, B13	191, 198
	97140-GP-59	247, B13	191, 198
	97110-GP	247, B13	191, 198
	97112-GP-59	247, B13	191, 198
12/5/13	98941	247, B13	191, 198
	G0283-GP	247, B13	191, 198
	97140-GP-59	247, B13	191, 198
	97110-GP	247, B13	191, 198
	97112-GP-59	247, B13	191, 198

The Division finds the following:

- Denials 247 and B13 – The insurance carrier submitted insufficient documentation to support that payment was issued for the disputed charges. As a result, the insurance carrier's denial is not supported.
- Denial 191 – The insurance carrier submitted insufficient documentation to support the denial of 191. As a result, the insurance carrier's denial is not supported.
- Denials 198 – The requestor submitted insufficient documentation to support that the services were preauthorized as indicated in # 1 above.

Review of the submitted documentation finds that dates of service December 4, 2013 and December 5, 2013 contain information/documentation to support that the disputed services rendered on December 4, 2013 and December 5, 2013 were not preauthorized pursuant to 28 Texas Administrative Code 134.600. The Division finds that reimbursement is not recommended for CPT Codes 98941, G0283-GP, 97140-GP-59, 97110-GP and 97112-GP-59 rendered December 4, 2013 and December 5, 2013.

3. The requestor seeks reimbursement for CPT Codes 98941, G0283-GP, 97140-GP-59, 97110-GP and 97112-GP-59 rendered on December 11, 2013 through January 9, 2014. The insurance carrier denied/reduced the disputed services with reason code(s):

- 247 – A payment or denial has already been recommended for this service.
- B13 – Previously paid. Payment for this claim/service may have been provided in a previous pay
- 285 – Please refer to the note above for a detailed explanation of reduction. Bill is denied per adjuster. Exceeds pre-authorization
- 6485 – At the adjusters request, no allowance was made

The table below outlines the denial reasons raised by the insurance carrier during the medical bill review process:

DOS	CPT code	EOB 5/15/14	EOB 2/12/14	EOB 2/7/14	EOB 1/28/14	EOB 1/14/14
12/11/13	98941	247, B13				285, 6485
	G0283-GP	247, B13				285, 6485
	97140-GP-59	247, B13				285, 6485
	97110-GP	247, B13				285, 6485
	97112-GP-59	247, B13				285, 6485
12/12/13	98941	247, B13				285, 6485
	G0283-GP	247, B13				285, 6485
	97140-GP-59	247, B13				285, 6485
	97110-GP	247, B13				285, 6485
	97112-GP-59	247, B13				285, 6485
12/19/13	98941	247, B13		285, 6485		
	G0283-GP	247, B13		285, 6485		
	97140-GP-59	247, B13		285, 6485		
	97110-GP	247, B13		285, 6485		
	97112-GP-59	247, B13		285, 6485		
1/8/14	98941	247, B13			285, 6485	
	G0283-GP	247, B13			285, 6485	
	97140-GP-59	247, B13			285, 6485	
	97110-GP	247, B13			285, 6485	
	97112-GP-59	247, B13			285, 6485	
1/9/14	98941	247, B13	285, 6485			
	G0283-GP	247, B13	285, 6485			
	97140-GP-59	247, B13	285, 6485			
	97110-GP	247, B13	285, 6485			
	97112-GP-59	247, B13	285, 6485			

The Division finds the following:

- Denials 247 and B13 – The insurance carrier submitted insufficient documentation to support that payment was issued for the disputed charges. As a result, the insurance carrier's denial is not supported.
- Denials 285 and 6485 – Review of the submitted documentation as indicated in # 1 of the "Findings" above, finds the requestor submitted insufficient documentation to support that the disputed services were preauthorized as required per 28 Texas Administrative Code §134.600.

Review of the submitted documentation finds that disputed dates of service December 11, 2013 through January 9, 2014 exceeded the preauthorization dates and units that were preauthorized by the insurance carrier. Further review of the submitted documentation does not support that the requestor accessed the concurrent review process to add and or extend the timeframes preauthorized by the insurance carrier. As a result, the Division finds that the requestor submitted insufficient documentation to support that the disputed services above were preauthorized as indicated in the position summary. The Division finds that the requestor is not entitled to reimbursement for these dates of service.

4. The requestor seeks reimbursement for dates of service October 3, 2013 through November 20, 2013. The insurance carrier denied/reduced the disputed services with reason code(s):

- 247 – A payment or denial has already been recommended for this service.
- B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment
- 191 – At the adjusters request no allowance was made
- 198 – Precertification/authorization exceeded

The table below outlines the denial reasons raised by the insurance carrier during the medical bill review process:

DOS	CPT code	EOB 5/15/14	EOB 12/23/13	EOB 11/26/13	EOB 11/5/13	EOB 11/12/13
10/3/13	98941	247, B13			191	
	G0283-GP	247, B13			191	
	97110-GP	247, B13			191	
	97112-GP-59	247, B13			191	
10/9/13	98941	247, B13			191	
	G0283-GP	247, B13			191	
	97140-GP-59	247, B13			191	
	97110-GP	247, B13			191	
	97112-GP-59	247, B13			191	
10/10/13	98941	247, B13			191	
	G0283-GP	247, B13			191	
	97140-GP-59	247, B13			191	
	97110-GP	247, B13			191	
	97112-GP-59	247, B13			191	
10/15/13	90791	247, B13				191
10/16/13	98941	247, B13			191	
	G0283-GP	247, B13			191	
	97140-GP-59	247, B13			191	
	97110-GP	247, B13			191	
	97112-GP-59	247, B13			191	
10/17/13	98941	247, B13			191	
	G0283-GP	247, B13			191	
	97140-GP-59	247, B13			191	
	97110-GP	247, B13			191	
	97112-GP-59	247, B13			191	
	99080-73		191, 198			
11/6/13	98941	247, B13		191		
	G0283-GP	247, B13		191		
	97140-GP-59	247, B13		191		
	97110-GP	247, B13		191		
	97112-GP-59	247, B13		191		
11/7/13	98941	247, B13		191		
	G0283-GP	247, B13		191		
	97140-GP-59	247, B13		191		
	97110-GP	247, B13		191		
	97112-GP-59	247, B13		191		

DOS	CPT code	EOB 5/15/14	EOB 12/23/13	EOB 12/10/13
11/11/13	90834	247, B13	191, 216	
11/13/13	98941	247, B13		191, 216
	G0283-GP	247, B13		191, 216
	97140-GP-59	247, B13		191, 216
	97110-GP	247, B13		191, 216
	97112-GP-59	247, B13		191, 216
11/14/13	90834	247, B13	191, 216	
11/19/13	90834	247, B13	191, 216	
11/20/13	90834	247, B13	191, 216	

The Division finds the following:

- Denials 216 –The requestor submitted documentation to support that the services in dispute rendered on November 11, 2013 through November 20, 2013 were preauthorized pursuant to 28 Texas Administrative Code §134.600. As a result, the insurance carrier's denial is not supported.
- Denials 247 and B13 – The insurance carrier submitted insufficient documentation to support that payment was issued for the disputed charges. As a result, the insurance carrier's denial is not supported.
- Denial 191 – The insurance carrier submitted insufficient documentation to support the denial of 191. As a result, the insurance carrier's denial is not supported.
- Denial 198 – The insurance carrier denied CPT Code 99080-73 for precertification/authorization exceeded. Per 28 Texas Administrative Code §134.600 DWC73s are not subject to preauthorization requirements, as a result, the insurance carrier's denial is not supported.
- The Division finds that the respondent's denial reasons are not supported as a result; the disputed services are eligible for reimbursement.

Per 28 Texas Administrative Code §134.203, "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

Per 28 Texas Administrative Code §134.203, "(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."

Date of Service October 3, 2013

- Procedure code 98941, service date October 3, 2013, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.65 multiplied by the geographic practice cost index (GPCI) for work of 1.009 is 0.65585. The practice expense (PE) RVU of 0.39 multiplied by the PE GPCI of 1.017 is 0.39663. The malpractice RVU of 0.03 multiplied by the malpractice GPCI of 0.834 is 0.02502. The sum of 1.0775 is multiplied by the Division conversion factor of $55.30 for a MAR of $59.59.
- Procedure code G0283, service date October 3, 2013, represents a professional service with reimbursement determined per §134.203(c). Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is subject to 50% reduction of the practice expense component. This procedure does not have the highest PE for this date. The PE reduced rate is $16.41.
- Procedure code 97110, service date October 3, 2013, represents a professional service with reimbursement determined per §134.203(c). Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is subject to 50% reduction of the practice expense component. This procedure does not have the highest PE for this date. The PE reduced rate is $39.07 at 4 units is $156.28.
- Procedure code 97112, service date October 3, 2013, represents a professional service with reimbursement determined per §134.203(c). Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is subject to 50% reduction of the practice expense component. This procedure has the highest PE for this date. The first unit is paid at $54.82. Per §134.203(h), reimbursement is the lesser of the MAR or the provider's usual and customary charge. The lesser amount is $47.56.

Date of Service October 9, 2013

- Procedure code 98941, service date October 9, 2013, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.65 multiplied by the geographic practice cost index (GPCI) for work of 1.009 is 0.65585. The practice expense (PE) RVU of 0.39 multiplied by the PE GPCI of 1.017 is 0.39663. The malpractice RVU of 0.03 multiplied by the malpractice GPCI of 0.834 is 0.02502. The sum of 1.0775 is multiplied by the Division conversion factor of $55.30 for a MAR of $59.59.
- Procedure code G0283, service date October 9, 2013, represents a professional service with reimbursement determined per §134.203(c). Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is subject to 50% reduction of the practice expense component. This procedure does not have the highest PE for this date. The PE reduced rate is $16.41.
- Procedure code 97140, service date October 9, 2013, represents a professional service with reimbursement determined per §134.203(c). Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is subject to 50% reduction of the practice expense component. This procedure does not have the highest PE for this date. The PE reduced rate is $36.83.
- Procedure code 97110, service date October 9, 2013, represents a professional service with reimbursement determined per §134.203(c). Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is subject to 50% reduction of the practice expense component. This procedure does not have the highest PE for this date. The PE reduced rate is $39.07 at 4 units is $156.28.
- Procedure code 97112, service date October 9, 2013, represents a professional service with reimbursement determined per §134.203(c). Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is subject to 50% reduction of the practice expense component. This procedure has the highest PE for this date. The first unit is paid at $54.82. Per §134.203(h), reimbursement is the lesser of the MAR or the provider's usual and customary charge. The lesser amount is $47.56.

Date of Service October 10, 2013

- Procedure code 98941, service date October 10, 2013, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.65 multiplied by the geographic practice cost index (GPCI) for work of 1.009 is 0.65585. The practice expense (PE) RVU of 0.39 multiplied by the PE GPCI of 1.017 is 0.39663. The malpractice RVU of 0.03 multiplied by the malpractice GPCI of 0.834 is 0.02502. The sum of 1.0775 is multiplied by the Division conversion factor of $55.30 for a MAR of $59.59.
- Procedure code G0283, service date October 10, 2013, represents a professional service with reimbursement determined per §134.203(c). Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is subject to 50% reduction of the practice expense component. This procedure does not have the highest PE for this date. The PE reduced rate is $16.41.
- Procedure code 97140, service date October 10, 2013, represents a professional service with reimbursement determined per §134.203(c). Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is subject to 50% reduction of the practice expense component. This procedure does not have the highest PE for this date. The PE reduced rate is $36.83.
- Procedure code 97110, service date October 10, 2013, represents a professional service with reimbursement determined per §134.203(c). Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is subject to 50% reduction of the practice expense component. This procedure does not have the highest PE for this date. The PE reduced rate is $39.07 at 4 units is $156.28.

- Procedure code 97112, service date October 10, 2013, represents a professional service with reimbursement determined per §134.203(c). Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is subject to 50% reduction of the practice expense component. This procedure has the highest PE for this date. The first unit is paid at $54.82. Per §134.203(h), reimbursement is the lesser of the MAR or the provider's usual and customary charge. The lesser amount is $47.56.

Date of Service October 15, 2013, CPT Code 90791

- The requestor submitted sufficient documentation to support the billing of the Psychiatric diagnostic evaluation. As a result, the requestor is entitled to reimbursement. The requestor seeks reimbursement in the amount of $300.00. The MAR amount is $246.80, therefore this amount is recommended.

Date of Service October 16, 2013

- Procedure code 98941, service date October 16, 2013, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.65 multiplied by the geographic practice cost index (GPCI) for work of 1.009 is 0.65585. The practice expense (PE) RVU of 0.39 multiplied by the PE GPCI of 1.017 is 0.39663. The malpractice RVU of 0.03 multiplied by the malpractice GPCI of 0.834 is 0.02502. The sum of 1.0775 is multiplied by the Division conversion factor of $55.30 for a MAR of $59.59.
- Procedure code G0283, service date October 16, 2013, represents a professional service with reimbursement determined per §134.203(c). Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is subject to 50% reduction of the practice expense component. This procedure does not have the highest PE for this date. The PE reduced rate is $16.41.
- Procedure code 97140, service date October 16, 2013, represents a professional service with reimbursement determined per §134.203(c). Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is subject to 50% reduction of the practice expense component. This procedure does not have the highest PE for this date. The PE reduced rate is $36.83.
- Procedure code 97110, service date October 16, 2013, represents a professional service with reimbursement determined per §134.203(c). Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is subject to 50% reduction of the practice expense component. This procedure does not have the highest PE for this date. The PE reduced rate is $39.07 at 4 units is $156.28.
- Procedure code 97112, service date October 16, 2013, represents a professional service with reimbursement determined per §134.203(c). Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is subject to 50% reduction of the practice expense component. This procedure has the highest PE for this date. The first unit is paid at $54.82. Per §134.203(h), reimbursement is the lesser of the MAR or the provider's usual and customary charge. The lesser amount is $47.56.

Date of Service October 17, 2013, CPT Code 99080-73

- Per 28 Texas Administrative Code §129.5 “(i) Notwithstanding any other provision of this title, a doctor may bill for, and a carrier shall reimburse, filing a complete Work Status Report required under this section or for providing a subsequent copy of a Work Status Report which was previously filed because the carrier, its agent, or the employer through its carrier, asks for an extra copy. The amount of reimbursement shall be $15. A doctor shall not bill in excess of $15 and shall not bill or be entitled to reimbursement for a Work Status Report which is not reimbursable under this section. Doctors are not required to submit a copy of the report being billed for with the bill if the report was previously provided. Doctors billing for Work Status Reports as permitted by this section shall do so as follows: (1) CPT code ‘99080’ with modifier ‘73’ shall be used when the doctor is billing for a report required under subsections (d)(1), (d)(2), and (f) of this section.” The requestor is entitled to reimbursement pursuant to 28 Texas Administrative Code §129.5 in the amount of $15.00.

Date of Service October 17, 2013

- Procedure code 98941, service date October 17, 2013, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.65 multiplied by the geographic practice cost index (GPCI) for work of 1.009 is 0.65585. The practice expense (PE) RVU of 0.39 multiplied by the PE GPCI of 1.017 is 0.39663. The malpractice RVU of 0.03 multiplied by the malpractice GPCI of 0.834 is 0.02502. The sum of 1.0775 is multiplied by the Division conversion factor of $55.30 for a MAR of $59.59.
- Procedure code G0283, service date October 17, 2013, represents a professional service with reimbursement determined per §134.203(c). Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is subject to 50% reduction of the practice expense component. This procedure does not have the highest PE for this date. The PE reduced rate is $16.41.
- Procedure code 97140, service date October 17, 2013, represents a professional service with reimbursement determined per §134.203(c). Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is subject to 50% reduction of the practice expense component. This procedure does not have the highest PE for this date. The PE reduced rate is $36.83.
- Procedure code 97110, service date October 17, 2013, represents a professional service with reimbursement determined per §134.203(c). Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is subject to 50% reduction of the practice expense component. This procedure does not have the highest PE for this date. The PE reduced rate is $39.07 at 4 units is $156.28.
- Procedure code 97112, service date October 17, 2013, represents a professional service with reimbursement determined per §134.203(c). Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is subject to 50% reduction of the practice expense component. This procedure has the highest PE for this date. The first unit is paid at $54.82. Per §134.203(h), reimbursement is the lesser of the MAR or the provider's usual and customary charge. The lesser amount is $47.56.

Date of Service November 6, 2013

- Procedure code 98941, service date November 6, 2013, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.65 multiplied by the geographic practice cost index (GPCI) for work of 1.009 is 0.65585. The practice expense (PE) RVU of 0.39 multiplied by the PE GPCI of 1.017 is 0.39663. The malpractice RVU of 0.03 multiplied by the malpractice GPCI of 0.834 is 0.02502. The sum of 1.0775 is multiplied by the Division conversion factor of $55.30 for a MAR of $59.59.
- Procedure code G0283, service date November 6, 2013, represents a professional service with reimbursement determined per §134.203(c). Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is subject to 50% reduction of the practice expense component. This procedure does not have the highest PE for this date. The PE reduced rate is $16.41.
- Procedure code 97140, service date November 6, 2013, represents a professional service with reimbursement determined per §134.203(c). Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is subject to 50% reduction of the practice expense component. This procedure does not have the highest PE for this date. The PE reduced rate is $36.83.
- Procedure code 97110, service date November 6, 2013, represents a professional service with reimbursement determined per §134.203(c). Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is subject to 50% reduction of the practice expense component. This procedure does not have the highest PE for this date. The PE reduced rate is $39.07 at 4 units is $156.28.

- Procedure code 97112, service date November 6, 2013, represents a professional service with reimbursement determined per §134.203(c). Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is subject to 50% reduction of the practice expense component. This procedure has the highest PE for this date. The first unit is paid at $54.82. Per §134.203(h), reimbursement is the lesser of the MAR or the provider's usual and customary charge. The lesser amount is $47.56.

Date of Service November 7, 2013

- Procedure code 98941, service date November 7, 2013, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.65 multiplied by the geographic practice cost index (GPCI) for work of 1.009 is 0.65585. The practice expense (PE) RVU of 0.39 multiplied by the PE GPCI of 1.017 is 0.39663. The malpractice RVU of 0.03 multiplied by the malpractice GPCI of 0.834 is 0.02502. The sum of 1.0775 is multiplied by the Division conversion factor of $55.30 for a MAR of $59.59.
- Procedure code G0283, service date November 7, 2013, represents a professional service with reimbursement determined per §134.203(c). Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is subject to 50% reduction of the practice expense component. This procedure does not have the highest PE for this date. The PE reduced rate is $16.41.
- Procedure code 97140, service date November 7, 2013, represents a professional service with reimbursement determined per §134.203(c). Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is subject to 50% reduction of the practice expense component. This procedure does not have the highest PE for this date. The PE reduced rate is $36.83.
- Procedure code 97110, service date November 7, 2013, represents a professional service with reimbursement determined per §134.203(c). Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is subject to 50% reduction of the practice expense component. This procedure does not have the highest PE for this date. The PE reduced rate is $39.07 at 4 units is $156.28.
- Procedure code 97112, service date November 7, 2013, represents a professional service with reimbursement determined per §134.203(c). Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is subject to 50% reduction of the practice expense component. This procedure has the highest PE for this date. The first unit is paid at $54.82. Per §134.203(h), reimbursement is the lesser of the MAR or the provider's usual and customary charge. The lesser amount is $47.56.

Date of service November 11, 2013 procedure Code 90834

- The requestor submitted sufficient documentation to support the billing of the psychotherapy service. As a result, the requestor is entitled to reimbursement. The requestor seeks reimbursement in the amount of $200.00. The MAR amount is $131.75, therefore this amount is recommended.

Date of Service November 13, 2013

- Procedure code 98941, service date November 13, 2013, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.65 multiplied by the geographic practice cost index (GPCI) for work of 1.009 is 0.65585. The practice expense (PE) RVU of 0.39 multiplied by the PE GPCI of 1.017 is 0.39663. The malpractice RVU of 0.03 multiplied by the malpractice GPCI of 0.834 is 0.02502. The sum of 1.0775 is multiplied by the Division conversion factor of $55.30 for a MAR of $59.59.

- Procedure code G0283, service date November 13, 2013, represents a professional service with reimbursement determined per §134.203(c). Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is subject to 50% reduction of the practice expense component. This procedure does not have the highest PE for this date. The PE reduced rate is $16.41.
- Procedure code 97140, service date November 13, 2013, represents a professional service with reimbursement determined per §134.203(c). Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is subject to 50% reduction of the practice expense component. This procedure does not have the highest PE for this date. The PE reduced rate is $36.83.
- Procedure code 97110, service date November 13, 2013, represents a professional service with reimbursement determined per §134.203(c). Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is subject to 50% reduction of the practice expense component. This procedure does not have the highest PE for this date. The PE reduced rate is $39.07 at 4 units is $156.28.
- Procedure code 97112, service date November 7, 2013, represents a professional service with reimbursement determined per §134.203(c). Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is subject to 50% reduction of the practice expense component. This procedure has the highest PE for this date. The first unit is paid at $54.82. Per §134.203(h), reimbursement is the lesser of the MAR or the provider's usual and customary charge. The lesser amount is $47.56.

Date of service November 14, 2013 procedure Code 90834

- The requestor submitted sufficient documentation to support the billing of the psychotherapy service. As a result, the requestor is entitled to reimbursement. The requestor seeks reimbursement in the amount of $200.00. The MAR amount is $131.75, therefore this amount is recommended.

Date of service November 19, 2013 procedure Code 90834

- The requestor submitted sufficient documentation to support the billing of the psychotherapy service. As a result, the requestor is entitled to reimbursement. The requestor seeks reimbursement in the amount of $200.00. The MAR amount is $131.75, therefore this amount is recommended.

Date of service November 20, 2013 procedure Code 90834

- The requestor submitted sufficient documentation to support the billing of the psychotherapy service. As a result, the requestor is entitled to reimbursement. The requestor seeks reimbursement in the amount of $200.00. The MAR amount is $131.75, therefore this amount is recommended.

5. The Division finds that the requestor is entitled to reimbursement in the amount of $3,285.33 for disputed dates of service October 3, 2013, October 9, 2013, October 10, 2013, October 15, 2013, October 16, 2013, October 17, 2013, November 6, 2013, November 7, 2013, November 11, 2013, November 13, 2013, November 14, 2013, November 19, 2013 and November 20, 2013.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $3,285.33.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $3,285.33 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		December 22, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.